Lumenos Plan

An option under the State Health Benefit Plan

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Table of Contents

Welcome to the Lumenos Plan!

The Lumenos plan (the Lumenos plan) is an innovative approach to health benefits for eligible employees of the State Health Benefit Plan (the company). The Lumenos plan is an option under the State Health Benefit Plan (the Plan).

With the Lumenos plan, you have health coverage available to you for which you and the company share the cost. This coverage has three components designed to work together to provide you flexibility and control in choosing the health care services you and your family members receive and in choosing how the cost of these services is paid. Bottom line, the Lumenos plan is designed to help you – and your family – take control of your health care dollars and decisions.

The Lumenos Plan – In Brief

The components of the Lumenos plan are:

Health Reimbursement Account (HRA)

As a participant in the Lumenos plan, the company will make an annual allocation to your own Health Reimbursement Account (HRA). You can use this account to cover 100% of the cost of covered services, up to the accrued allocation in your account. Covered services include routine medical services (such as office visits and lab tests), and preventive care (such as health screenings and physicals).

Traditional Health Coverage

In addition to your HRA, the Lumenos plan offers Traditional Health Coverage to protect you and your family in case you have significant health care expenses or your expenses exceed your annual company allocation. This coverage is called Traditional Health Coverage, and is made available by your employer on a self-insured basis. This coverage takes effect after using your annual company allocation on covered services and paying your Bridge – a specified amount that you must pay out-of-pocket on covered health services.

Any day and dollar limits associated with specific benefits under the Lumenos plan will only apply under the Traditional Health Coverage component, and not while you are in your Health Reimbursement Account and Bridge.

Online Health Site

To help you make the most out of your Lumenos plan coverage – and make the best use of your health care dollars – you'll have access to an online Health Site. The Online Health Site features a combination of financial tools and health tools to help you make informed decisions about your health care.

Before using your Lumenos plan benefits, you need to know – and understand – how the different components of the Lumenos plan work and how they work together to provide your health coverage. That's the purpose of this Plan summary. You should read it thoroughly and refer to it frequently. If you have any questions about how the Lumenos plan works, contact Customer Service at (866) 835-6863.

NOTE: Words and phrases within this document that are denoted with initial capitalization have the meaning ascribed to them within the document itself, or within the Terms to Know section.

About This Summary

This summary – a Summary Plan Description (SPD), provides information about the Lumenos plan option under the Plan effective January 1, 2006. For other terms and conditions related to the Plan, see the company's legal document describing the Plan.

The company reserves the right to amend or terminate the Lumenos plan at any time. You will be notified of any changes that affect your benefits, as required by federal law.

Joining the Lumenos Plan

For specific information on joining the Lumenos plan, see:

- Eligibility
- Enrolling in the Lumenos plan
- When Coverage Begins
- Cost of Coverage

Eligibility

You and your dependent(s) may be covered under the Lumenos plan depending on your eligibility for benefits. For more information, see:

- Your Eligibility
- Dependent Eligibility

Your Eligibility

You are eligible to enroll yourself and your eligible dependents in the Lumenos Program on the first day of the month following one full calendar month of employment if you meet the following criteria:

- A full-time employee of the State of Georgia.
- You work at least 30 hours a week consistently and your employment is expected to last at least nine months.

Dependent Eligibility

You can also choose to cover your eligible dependents under the Lumenos plan. Eligible dependents include:

- **Your legally married spouse (as defined by the State of Georgia)**
- **Your unmarried child who is under 19 years of age** unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody.
- **Stepchildren under age 19 who** live with you at least 180 days per year and for whom you can provide documentation satisfactory to the plan that they are your dependents.
- **Other children under age 19** if they live with you permanently and legally depend on you for financial support-as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction.
- **Your natural children, legally adopted children or stepchildren 19 or older from categories 1 and 2 above** who are physically or mentally disabled prior to reaching age 19 and who depend on you for primary support may continue their existing Plan coverage past age 19.

- **Your natural children, legally adopted children, stepchildren or other children ages 19 through 25 from categories 1, 2, and 3 above** who are registered Full-time Students at fully accredited schools, colleges, universities or nurse training institutions and, if employed, who are not eligible for a medical benefit plan from their employer. The number of credit hours required for Full-time Student status is defined by the school in which the child is enrolled

If an unmarried child reaches age 19 and is not a full-time student, you may continue coverage for that child if he or she meets the criteria listed below prior to age 19:

- incapable of self-support due to mental retardation or a physical handicap
- dependent on you for support and maintenance or dependent on other care providers for lifetime care and supervision

You must provide proof of your child's incapacity to the State Health Benefit Plan within 90 days after coverage would otherwise terminate. The Plan administrator may ask for proof of incapacity and dependency at any reasonable time. While the Plan requires that coverage requests be made within a specific time period, the documentation required to *support your request* may be filed, if necessary, within 60 days following the deadline to file the coverage request.

If your spouse also works for the State of Georgia, he or she may be covered as an employee rather than a dependent. If both parents are employees of the State of Georgia only one parent can cover the children.

Enrolling in the Lumenos Plan

If you want coverage under the Lumenos plan, you must enroll for this coverage by completing an enrollment form within 31 days of first becoming eligible and according to the process defined by the State Health Benefit Plan in the enrollment materials. Forms are available by contacting

If you have enrolled for dependent coverage, coverage for your eligible dependents is effective on the same date your coverage becomes effective.

NOTE: If you join the Lumenos plan at any time other than at the beginning of the Plan year January 1, 2006 the initial amount allocated to your HRA will be prorated based on the number of months left in the Plan year.

For additional information regarding the enrollment process, see:

- ID Cards
- Family Status Changes
- Special Enrollment Period

ID Cards

The Lumenos plan requires you to use an identification card to receive benefits. You will need to present the card each time you visit a health provider.

When you visit providers who offer discounts and present your ID card, your claim – in most cases – will be submitted by the provider to the Claims Administrator. If you don't present

your ID card, you may need to pay for services yourself and file a claim for reimbursement at a later date.

When you visit providers who do not offer discounts, you should show your ID card and you may need to pay for services yourself and file a claim for reimbursement at a later date.

Change in Status

If you wish to change your Lumenos plan coverage due to an eligible Change in Status, you must request that change within **31** days of the event. If the change is because of birth, adoption or placement of a child for adoption, coverage will be retroactive to the date of the birth, adoption or placement for adoption. In all other circumstances coverage will be effective the later of the Plan's effective date or your enrollment after that date pursuant to the Plan's eligibility rules. If you do not request a change within **31** days, you will have to wait until the next enrollment period to change your coverage (unless you experience another Change in Status event).

The following is a list of the applicable change in status events:

- birth, adoption or the placement of a child for adoption
- marriage
- divorce or legal separation
- death of a dependent
- a dependent's losing or gaining eligibility
- a change in employment status for you or your spouse that results in change in medical coverage for you or your dependents
- you or your spouse enrolling (or losing coverage) in Medicare or Medicaid
- a court order requiring you to cover an eligible dependent

IMPORTANT! A qualified medical child support order (QMCSO) is a legal judgment, decree or order issued under a state domestic relations law. A QMCSO creates or recognizes the rights of a child to coverage for health care benefits.

Under a QMCSO, you can be required to provide coverage to your eligible dependent children under this Plan.

In order to qualify as a QMCSO, the order must meet specific requirements provided by the Plan Administrator. The Plan Administrator will notify you if any of your children are affected by a QMCSO. You may contact the Plan Administrator to request a free copy of the Lumenos plan's procedures used to determine whether a medical child support order is qualified.

NOTE: Your newborn child is considered your dependent under the Lumenos plan immediately after birth until discharged from the hospital or 7 days old. If you want to continue coverage beyond that date, you must enroll within **31** days of the date of birth.

Special Enrollment Period

If you or an eligible dependent decline to participate in the Plan because of other health care coverage, you may have the opportunity to enroll in the Plan at a later date if you lose eligibility for the other coverage.

At the time you decline Plan coverage, you must state, in writing, that your reason for declining coverage is because you or your dependents have other coverage. If, in the future, you or your dependents lose eligibility for the other coverage, you may enroll in the Plan – including the Lumenos plan so long as you enroll within 31 days after the date the other coverage ends. You or your dependents are not eligible for special enrollment under this Plan if you lose coverage due to a failure to pay premiums, failure to enroll during annual enrollment or for reasons of fraud.

If you enroll in the Lumenos plan through the Plan's special enrollment provisions, your Lumenos plan coverage will be effective on the later of the Plan's effective date or your enrollment after that date pursuant to the Plan's eligibility rules.

When Coverage Begins

The Lumenos plan coverage begins on the later of the Plan's effective date or your enrollment after that date pursuant to the Plan's eligibility rules.

Cost of Coverage

You and the company share the cost of the coverage you choose. Your cost for this coverage will be deducted from your pay each pay period on a *before*-tax basis. This means that your cost for coverage is taken from your salary before income and Social Security taxes are calculated. This reduces your taxable income and the amount of taxes you pay and the end result is that your take home pay is higher than it would be if you paid your share of coverage under the Plan with after-tax dollars.

Your salary contribution for the cost of coverage goes only to offset the employer's cost for the traditional health coverage component of the plan. No portion of your salary contribution goes into the Health Reimbursement Account.

For information on your specific contribution rates, contact your personnel/payroll office.

How the Lumenos Plan Works

The Lumenos plan is an innovative approach to health benefits that puts you in charge of the money you spend for health care services and helps you get the most out of your company-sponsored health coverage. With the Lumenos plan, you have flexibility and control in choosing the health care services you and your family members receive – and in determining how the cost of these services is paid.

Health Reimbursement Account (HRA)

Through the Lumenos plan, the company makes an annual allocation to a Health Reimbursement Account (HRA) for you and your covered dependents (the HRA is a bookkeeping account, and not a trust of any sort). You can use your HRA to pay for Covered Services not otherwise covered by the Traditional Health Coverage such as the cost of routine medical expenses like office visits and lab tests, as well as preventive care – including health screenings, physicals and other covered services, for you and your eligible dependents.

In addition, you can use your HRA to cover other Lumenos plan costs including: any covered services above the Reasonable and Customary amount, services beyond the annual benefit maximums and coinsurance you incur in your Traditional Health Coverage.

The HRA is only available for IRC Section 213(d) Qualified Medical Expenses, and even these are subject to the terms of the benefit plan; you can never take amounts out of the HRA in cash for other than the reimbursement of expenses covered under the Lumenos plan.

IMPORTANT! Any HRA amounts that you use to cover expenses above the Reasonable and Customary amount or for services beyond the annual benefit maximums will not count toward your annual out-of-pocket maximum.

The annual company allocation to your HRA is:

- $500 – single coverage
- $1,000 – family coverage (combined family limit)

NOTE: If you join the Lumenos plan at any time other than at the beginning of the Plan year (January 1, 2006), the initial amount allocated to your HRA will be prorated based on the number of months left in the Plan year.

The HRA approach gives you the opportunity to build your available health care dollars over time. If you don't use the full amount of your HRA each Plan year, the remaining amount can be rolled over and used the next Plan year.

NOTE: If you experience a change in family status during the Plan year that results in a reduction in coverage (i.e. from family to single), your allocation will not change until the beginning of the next Plan year. If the change in family status results in an increase from in coverage (i.e. from single to family, you will receive an additional allocation equal to the difference between the levels (i.e. single to family) allocation. If your participation in the Lumenos plan ends for any reason, any balance in your account will be forfeited back to the company.

Bridge

If you use your annual company allocation to your account and you need additional services from the Traditional Health Coverage, you will have to pay a specified out-of-pocket amount before the Traditional Health Coverage begins. This is called your Bridge.

Your Bridge is:

- $500 -single coverage
- $1,000 - family coverage

If you have been in the Lumenos plan for more than a year, you may have money saved up in your account from previous years. If so, you may have enough to cover your Bridge – and therefore not pay anything out of your pocket before the Traditional Health Coverage begins.

Choice of Providers

Lumenos offers discounts to consumers through partnerships with providers throughout the nation.

Members have automatic access to provider directories, free of charge, by accessing the member site at www.lumenos.com, or by contacting the Lumenos Customer Service Department at (866) 835-6863.

With the Lumenos plan, you have the flexibility to see any licensed health care provider you choose. The Doctors Plus Directory can help you locate a provider near you. The level of your health coverage under the Lumenos plan depends on whether you use providers who offer Lumenos discounts or providers who do not offer Lumenos discounts.

Providers Who Offer Lumenos Discounts

If you visit a provider who offers Lumenos discounts, you will receive the highest level of benefits offered under the Lumenos plan. These providers have agreed to charge a "discounted fee" for their services. You will never pay for charges in excess of the discounted price, and in most cases, the provider will file a claim for you after your visit.

Providers Who Do Not Offer Lumenos Discounts

If you visit a provider who does not offer Lumenos discounts, you may have to pay their full price at the time of service, then file a claim for reimbursement. Under your Traditional Health Coverage, you will be responsible for coinsurance, as well as the difference between the charge for the service and the Reasonable and Customary charges.

Traditional Health Coverage

In addition to your account, the Lumenos plan offers additional health coverage to protect you and your family in case you incur significant health care expenses or if your expenses exceed your annual company allocation. This coverage begins once you have used the entire annual company allocation on covered services and pay your Bridge.

Coinsurance

When using the Traditional Health Coverage, you pay a certain percentage of the cost of covered services through coinsurance. Generally, the Traditional Health Coverage pays 60% to 90% of the cost of most covered services, and your coinsurance amount is 10% to 40% up until a limit called the coinsurance maximum. The coinsurance maximum is the most you pay in coinsurance expenses for covered services in a Plan year.

The annual coinsurance maximums for the Traditional Health Coverage are:

- $1,000 -single coverage
- $2,000 - family coverage

Member Advance

In some cases, you will see an "advance" listed on the Explanation of Benefits (EOB) you receive in the mail after receiving medical services. If necessary, an advance may need to be made to your account to cover the cost of medical expenses. This occurs when a claim has been paid but there are insufficient funds in your account to cover the entire expense.

When there is an advance, your payment will automatically deduct the cost of the advance from a future claim (including claims for preventive care services) in order to reconcile your account.

Out-of-Pocket Maximum

The Lumenos plan's out-of-pocket maximum is the most that you will pay toward covered health expenses in a Plan year. Once you reach the out-of-pocket maximum under the Lumenos plan, the Plan pays 100% of covered services for providers who offer discounts and 100% of Reasonable and Customary charges for providers who do not offer discounts.

The Lumenos plan's out-of-pocket maximums are:

- $1,500 - single coverage
- $3,000 - family coverage

IMPORTANT! Amounts you pay toward the cost of certain medical services will not count toward your annual out-of-pocket maximum. These include any cost you pay:

- for any service that is not a covered service under the Traditional Health Coverage
- toward expenses that are in excess of Reasonable and Customary charges
- toward expenses that are in excess of annual maximums

Lifetime Benefit Maximum

All benefits paid under any Lumenos plan (whether as an active employee or retiree) apply towards the Lifetime Maximum described herein. You and your covered dependent(s) each have a lifetime benefit maximum of $2,000,000 under the Plan. This is the total amount of benefits you can receive under the Plan in a lifetime. Once you or your covered dependent reach this limit, you are responsible for the full cost of any additional services you or your dependent(s) may receive.

Inpatient Admission

To help assure that your treatment is Medically Necessary under the terms of your health plan, We have partnered with FutureHealth to provide admission and concurrent review of inpatient admissions for hospital (medical and surgical), rehabilitation, skilled nursing facility, psychiatric hospital and detoxification facility. Transplant services require pre-certification before scheduling the procedure. For these services you or your physician must notify the plan at the number listed on the back of your Lumenos ID card prior to admission.

In case of an emergency, notify the plan within 48 hours of your admission by calling the number listed on the back of your Lumenos plan ID card.

This notification process assists us in helping you manage your health care. If you have a serious or chronic condition, a Personal Health Coach will be available to help you or your dependent in coordinating resources.

NOTE: Under federal law, benefits for any hospital stay in connection with childbirth for the mother or the newborn cannot be restricted to less than:

- 48 hours – following a normal vaginal delivery
- 96 hours – following a cesarean section

Although you are encouraged to call, neither you nor your physician needs to pre-notify the plan for any length of stay less than these periods for childbirth. However, the physician, after consulting with the mother, may discharge the mother or newborn before the 48- or 96-hour timeframe noted above.

Online Health Site

The Lumenos plan offers online health and financial tools to help you manage your health and make the best use of your health care dollars.

Health Tools

The Lumenos plan offers several resources designed to help you stay healthy, deal with an illness or injury and prepare for a medical procedure or treatment, including:

- Doctors Plus Directory
- My e-Checkup
- My Family Health File
- Personal Health Coach
- 24-Hour Nurse Advice

Whether you're going for a routine check-up, managing a medical condition or getting ready for surgery, the Lumenos Online Health Site delivers the information and support you need around these topics and more.

Doctors Plus Directory

The Doctors Plus Directory will help you locate – and find information about – doctors and other health care services in your area. Whether you need a specialist, a pharmacy, a hospital, vision care, a chiropractor or a nutritionist, you'll find it in one place. In addition, this directory will help you:

- find out which providers offer discounts
- find an estimate on how much you'll typically be charged for certain services
- get background information about physicians
- view provider recommendations from other consumers
- get directions and a handy map

To access the Doctors Plus Directory, log in to www.lumenos.com. By entering your user name and password, you will be able to access the secure site and search for providers and pertinent information regarding ratings, discounts, etc. You can also obtain a hard copy of the Doctors Plus Directory by calling Customer Service at (866) 835-6863.

My e-Checkup

Evaluate your overall health, help identify risks and find out how to help optimize your health. Use My e-Checkup to prepare for a routine physical – evaluate your health online, print out your family health history to share with your doctor, and find out what questions you should ask and what tests your doctor should perform.

My Family Health File

Store your family's medical records online at one secure, convenient location. Well-managed records help you and your doctor plan your preventive care and treatment.

Personal Health Coach

Through a partnership with FutureHealth Corporation, the Lumenos plan can provide you a Personal Health Coach. A Personal Health Coach is a registered nurse who assists you in receiving available health care services when you are faced with a serious illness or ongoing health problem. If the claims review indicates you might benefit from having a Personal Health Coach, one will contact you to discuss your needs.

This confidential service is designed to help you use your benefits most effectively, answer health care questions, arrange for treatment, coordinate your care and help you follow through with your doctor's instructions. The Personal Health Coach will work with you to coordinate your health care.

24-Hour Nurse Advice Line

Nurse Line is staffed 24 hours a day seven days a week by registered nurses. Nurses provide you and your family members with health care education and decision support for routine health conditions.

Financial Tools

The Lumenos plan offers online financial tools to help you keep track of your health care dollars. Plus you can track your claims for covered services. You can review what you've spent on health care, view your HRA balance or look up the status of a particular claim any time of the day.

Covered Services

Services for which your Traditional Health Coverage will pay benefits include the following hospital and medical services and supplies for treatment of an injury or disease. Most services received from providers who offer discounts will be covered at 90% of discounted fees**.** Most services received from providers who do not offer discounts will be covered at 60% of Reasonable and Customary charges (as determined by the Plan Administrator). Only those services, supplies and treatments that are for the treatment of an injury or disease, Medically Necessary (as determined by the Plan Administrator) and rendered by a licensed provider are covered, according to Lumenos plan provisions.

This section provides a detailed description of services covered under Traditional Health Coverage. Services for which your Traditional Health Coverage will pay benefits include the following:

- Professional Services
- Maternity Care
- Mental Health and Chemical Dependency
- Hospital and Facility Services

Professional Services

This section provides a detailed description of the eligible professional services. Most services received from providers who offer discounts will be covered at 90% of discounted fees or 60% of Reasonable and Customary charges for providers who do not offer discounts.

Allergy Care – Injections and Tests

Allergy care is covered when administered by a physician, allergist, or specialist. Serum is covered only when received and administered within the provider's office. If received from a pharmacy, the serum may be covered under the pharmaceutical benefit. The following services are covered:

- Allergy Injections
- Allergy Tests

Allergy Injections- Immunotherapy

Also called allergy desensitization or allergy shots; immunotherapy is given to increase a person's tolerance to the substances that provoke allergy symptoms (allergens). Allergy shots reduce the sensitivity to certain substances but do not cure allergies.

Allergy Tests

- An allergy **skin test**, also called a scratch test, is used to identify the substances that are causing allergy symptoms. It is the application of the allergen extract to the skin, and then scratching or pricking the skin to allow exposure, and evaluating the skin's reaction.
- **Scratch Test -** In this test, one or more small scratches or superficial cuts are made in the skin, and a minute amount of the substance to be tested is inserted in the scratches and allowed to remain there for a short time. If no reaction has

occurred after 30 minutes, the substance is removed and the test is considered negative. If there is redness or swelling at the scratch sites, the test is considered positive.

- **RAST** (radioallergosorbent test) is a blood test used to identify the substances that are causing allergy symptoms and to estimate a relative sensitivity.

Ambulance

Professional **ground transportation ambulance** services are covered in the following circumstances:

- When used to transport the patient from the place of accidental injury or serious medical incident to the nearest facility where treatment can be given.
- To transport a patient from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the patient.
- To transport a patient from hospital to home, skilled nursing facility or nursing home when the patient cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available.
- To transport a patient from home to hospital for Medically Necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the patient.
- To transport a patient upon medical stabilization from a non-discounted facility to a discounted facility when they were admitted due to a medical emergency to a non-discounted facility.

Coverage is provided for **air ambulance** transport for medical emergencies in the following circumstances:

- Patient requires transport to a hospital or from one hospital to another because the first hospital does not have the required services and/or facilities to treat the patient; and ground transportation is not medically appropriate because of the distance involved,
- Or because the patient has an unstable condition requiring medical supervision and rapid transport.

Notification is required except in a life threatening circumstance. Ambulance services are covered at 90% of discounted fees for providers who offer discounts, and 90% of charges for providers who do not offer discounts.

Anesthesia

The administration of anesthesia, other than local infiltration anesthesia, in connection with a covered surgical procedure, and provided the anesthesia is administered and charged for by a physician other than the operating surgeon or his assistant.

BioFeedback

Biofeedback is a process by which a person learns to influence involuntary bodily processes by watching a monitoring device that feeds back relevant physiologic information to them, such as skin temperature, muscle tone, brain waves, or respiration. Biofeedback can be used to treat a wide variety of conditions and diseases ranging from stress, alcohol and

other addictions, sleep disorders, epilepsy, respiratory problems, and fecal and urinary incontinence, muscle spasms, partial paralysis or muscle dysfunction caused by injury, migraine headaches, hypertension, and a variety of vascular disorders.

Blood Transfusions

Coverage is provided for blood transfusions to maintain or replace blood volume, to provide deficient blood elements and improve coagulation, to maintain or improve transport of oxygen, and in exchange for blood that has been removed in the treatment of Rh incompatibility in the newborn, liver failure in which toxins accumulate in the blood, or in some other types of toxemia.

Coverage is included for the following:

- Autologous
- Direct Donation
- Regular Administration
- Blood Products

Cardiac Rehabilitation Therapy

Coverage for cardiac rehabilitation therapy is provided in two phases. Phase I begins during/after the acute event (i.e. by-pass surgery, myocardial infarction, angioplasty). It includes nursing services, physical therapy and teaching the patient how to deal with his/her condition. Phase II is a hospital based outpatient program after inpatient hospital discharge. It is physician directed with active treatment and EKG monitoring at a frequency of three (3) times per week for approximately twelve (12) weeks. Benefits are limited to 40 visits per person per Plan year.

Chiropractic

Chiropractic services are defined as those services for the detection and correction by manual or mechanical means of nerve interference resulting from or related to misalignment or partial dislocation of or in the vertebral column. Coverage includes initial consultation and treatment. Benefits for chiropractic treatment are limited to a maximum of 20 visits per person per Plan year.

Dental Services and Oral Surgery

Charges for care rendered by a physician or dentist, which are required as a result of an accidental injury to the jaws, sound natural teeth, mouth or face, provided care commences within 90 days of the accident. Injury as a result of chewing or biting will not be considered an accidental injury.

Charges for surgical benefits for cutting procedures for the treatment of disease, injuries, fractures and dislocations of the jaw when the service is performed by a physician or dentist are also considered covered services.

NOTE: Normal extraction and care of teeth and structures directly supporting the teeth are not covered.

Diagnostic Labs and X-rays

Coverage is provided when services are performed to diagnose specific symptoms or rule out medical conditions. Services include:

- Diagnostic X-ray, consisting of radiology, ultrasound, nuclear medicine and magnetic resonance imaging.
- Diagnostic laboratory and pathology tests.
- Diagnostic medical procedures consisting of EKG, EEG, and other electronic diagnostic medical procedures.
- Pre-admission presurgical tests which are made prior to a covered person's inpatient or outpatient surgery.

For pre-admission and/or post-release testing to be covered under the Lumenos plan, your doctor must specify required tests and approve the facility for testing. In most cases, the tests can be performed in the outpatient department of a hospital, at an independent medical testing laboratory or in your doctor's office.

Pre-admission tests will be covered even if hospitalization is delayed, postponed or cancelled.

NOTE: Lab and x-ray services received in the absence of a diagnosis are not covered, with the exception of those specifically noted in the preventive care section.

Durable Medical Equipment

Coverage is provided for rental or, at the discretion of the Plan, purchase of Durable Medical Equipment, which is prescribed by a professional provider and required for therapeutic use.

If purchased, charges for repair or Medically Necessary replacement of Durable Medical Equipment will be considered a covered expense.

Includes, but not limited to crutches, commodes, hospital beds, nebulizers, monitoring equipment, wheelchairs, glucometers and blood pressure monitors with a provider's prescription and an applicable diagnosis.

NOTE: Coverage for replacement of durable medical equipment due to growth of the individual is also provided.

Coverage for DME does not include exercise equipment, equipment that is not solely for the use of the patient, comfort items, routine maintenance, or DME for the convenience of the patient. Consumable supplies are not covered, except for those that are Medically Necessary for the function of the authorized DME.

Family Planning

Coverage for family planning is provided for:

- D & C/Abortion – therapeutic or voluntary
- Diaphragm – Device and/or fitting
- IUD – Device and/or insertion and removal
- Tubal ligation
- Vasectomy
- Sterilization

Contraceptives administered in a doctor's office are covered, such as Depo-Provera ®.

Note: Reversal of sterilization is not a covered service.

Foreign Claims

Claims for services rendered while you are out of the country are reimbursed at 90% for emergent care, and 60% for non-emergent care.

All monetary conversions and rate of exchange are calculated based on the date of service.

Hearing Exam

Routine hearing exams to detect/prevent auditory deterioration are limited to one exam per person per Plan year.

Home Health Care

Home Health Care expenses are covered if the services are provided by a licensed Home Health Care Agency, and:

- The charge is made by a Home Health Care Agency
- The care is given according to a Home Health Care treatment plan
- The care is given to a person in his or her home

Home Health expenses are charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available
- Part-time or intermittent home health aide services for patient care
- Physical, occupational and speech therapy
- The following to the extent they would have been covered under this Plan if the person had been confined in a hospital or convalescent facility:

  Medical supplies

  Drugs and medicines provided by a physician

  Lab services provided by a home health care agency

The following expenses are not considered payable under Home Health Care:

- Services or supplies that are not part of the home health care treatment plan
- Services of a person who usually lives with the patient or who is a member of the patient's family
- Services of a social worker
- Transportation

Hospice Care

Hospice is a health care program providing a coordinated set of services rendered at home, in an outpatient setting or in an institutional setting for those suffering from a condition that has a terminal prognosis.

To be covered, the Hospice program must be licensed and the attending physician must certify that the terminally ill covered person has a life expectancy of six months or less. Charges incurred during periods of remission are not eligible under the provision of the Plan.

Hospice care for you and your eligible dependents is covered for up to six (6) months. A Personal Health Coach is available to coordinate coverage beyond six (6) months.

Services and supplies typically provided and billed by a Hospice are: Inpatient care;

- Nutrition counseling and special meals;
- Part-time nursing;
- Homemaker services;
- Bereavement counseling for immediate family members during the six month period following the date of death, limited to a combined maximum of $500 per episode (Immediate family members include husband, wife, and children);
- Respite care – limited to 5 days per episode;
- Physical and chemical therapy.

Infertility Treatment

Coverage is provided for the initial evaluation treatment and correction of the underlying condition only.

Procedures that may produce a pregnancy, but do not correct the underlying cause of the infertility are not covered.

Not Covered Treatments:

- Artificial Insemination
- Drug Therapy
- In-vitro fertilization
- Gamete (GIFT) and zygote (ZIFT) intrafallopian transfer procedures
- Drugs related to the inducement of pregnancy

Medical Supplies

Medical supplies that are prescribed by a licensed provider for a medical condition or diagnosis are covered, ***except*** for over the counter supplies. Over the counter supplies are ***excluded*** from the Lumenos plan.

Examples of medical supplies are diabetic supplies (lancets, glucometers, syringes, if not covered under the pharmacy benefit), injectables and ostomy supplies (including medical equipment and supplies directly related to ostomy care when surgery creates an opening for drainage from the kidney, the small intestines or the colon). Glucomoters and blood pressure monitors with a provider's prescription and an applicable diagnosis are also covered.

Orthotic Devices

Coverage is provided for orthotic devices (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including custom shoes and custom molded inserts, if prescribed by a physician. Orthopedic shoes are only covered when an integral part of a brace.

Podiatry

Coverage is provided for certain surgical podiatry services, including incision and drainage of infected tissue of the foot, removal of lesions of the foot, removal or debridement of infected toenails, and treatment of fractures and dislocations of bones of the foot. Podiatry services not covered are those procedures considered to be a part of a routine foot care, or of a cosmetic nature, such as treatment of corns, calluses, non-surgical care of toenails, fallen arches and other symptomatic complaints of the feet.

Preventive Care

The Lumenos plan covers preventive services based on guidelines from the U. S. Preventive Services Task Force, American Cancer Society, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics. The preventive benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions to prevent avoidable premature injury, illness and death.

All discounted rates will be paid by the Plan at 100% up to $500 per person per Plan year for providers who offer discounts, with no out-of-pocket responsibility for preventive services. Services that fall outside of the Preventive Care Benefit and other services performed during a preventive office visit will be considered for coverage under your account and/or Traditional Health Coverage portion of your plan.

Well Baby and Well Child Care

Baby/Child Preventive Care Office Visits

- Six (6) visits the first year
- Three (3) visits the second year
- Annual visit from ages 2 through 18

Baby/Child Screening Tests (annually, unless otherwise indicated):

- Lead Level Tests (once between 9 and 12 months)
- Vision screenings
- Hearing screenings
- Routine pelvic exam, Pap test and contraceptive management (screen all females who are 18, or have been sexually active, whichever comes first)

Baby/ Child Immunizations

Note: Actual dosing regimen to be determined by physician.

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- H. Influenza type b
- Polio
- Measles, Mumps, Rubella (MMR)
- Varicella (chicken pox)
- Influenza – flu shot (Over age 6 months. Doctor may give this vaccine if the child is at high risk or to reduce the risk of the child getting the flu)

- Pneumococcal Conjugate (pneumonia)

Adult Preventive Care

Adult Preventive Care Office Visits

- Periodic preventive visit (up to one annual visit, after age 18)

Adult Screening Tests (annually, unless otherwise indicated):

- Coronary Artery Disease: Periodic cholesterol and lipid screening for men beginning at age 35 and women age 45
- Clinical breast exam and mammogram – annual starting at age 40
- Routine pelvic exam, Pap test and contraceptive management (screen all females who are 18, or have been sexually active, whichever comes first)
- Colorectal Cancer Screenings: Annual fecal occult blood testing or flexible sigmoidoscopy every 3-5 years or colonoscopy every 10 years – starting at age 50
- Prostate Cancer Screenings: Digital rectal examination (DRE) and Prostate Specific Antigen (PSA) at discretion of physician and patient – starting at age 50
- Diabetes (Type II Diabetes) Screening - Periodic blood glucose testing for high-risk individuals (e.g. hypertension, hyperlipidemia)
- Osteoporosis Screening - Periodic bone density screening for women over age 65 and for women over age 60 with increased risk for osteoporotic fractures

Adult Immunizations

- Influenza
- Pneumococcal Conjugate (pneumonia)
- Tetanus /Diphtheria (DtaP)
- Measles, Mumps, Rubella (MMR) – for individuals under the age of 50 without previous immunization
- Hepatitis A – Recommended for high risk groups, such as international travelers, workers in food service or health care industry
- Hepatitis B and Varicella – Recommended for high risk individuals
- Meningococcal – Considered for college students who live in dormitories and have a slightly increased risk of getting meningococcal disease

Private Duty Nursing

Coverage is provided for the services of a private duty nurse on an outpatient basis only. Nursing services must be rendered by a nurse who does not reside in the patient's home, or who is not a member of the immediate family. To be covered, the physician in charge of the case must certify that the patient's condition requires the requested care, which can only be provided by an RN or LPN. Private duty nursing applies only for care given in the patient's home and not part of the home health care agency's plan of treatment.

Professional Services

Professional services are those services billed by a provider's office rather than by a facility – such as office visits and inpatient hospital visits. Covered professional services are:

- Office Visits - Visits made by patients to health service providers' offices for diagnosis, treatment, and follow-up.
- Inpatient Hospital Visit - A visit by a provider for persons admitted to health facilities which provide room and board, for the purpose of observation, care, diagnosis or treatment.
- Home Visit – Visit made by a provider to a patient's home for diagnosis, treatment and follow-up.

Prosthetics

Coverage is provided for the purchase and fitting of external prosthetic appliances which are used as a replacement or substitute for a missing body part, and are necessary for the alleviation or correction of illness, injury, or congenital defect.

Replacement or repair, as appropriate, of external prosthetic appliances is covered if necessitated by such circumstances as normal anatomical growth, physical changes which render the device ineffective, or excessive wear.

Coverage for internal prosthetic appliances includes the purchase, maintenance, or repair of permanent or temporary internal aids and supports for defective body parts, specifically, intraocular lenses, artificial heart valves, cardiac pacemakers, artificial joints, and other surgical materials such as screw nails, sutures and wire mesh.

Second Surgical Opinion

Coverage is provided for an opinion provided by a second physician, when one physician recommends surgery to an individual. Second opinions will be covered at 90% for providers who offer discounts, and 60% for providers who do not offer discounts.

Surgery

Coverage is provided for surgery rendered in both inpatient and outpatient settings for the treatment of disease or injury. Separate payment will not be made for pre-operative care or post-operative care normally provided by the surgeon as part of the surgical procedure.

NOTE: Prior authorization is required for:

- Medical necessity for procedures that could be considered cosmetic
- Transplants

Breast reconstruction coverage

Other covered services also include breast reconstruction – for you and your covered dependents – if you or your family members received benefits for a mastectomy, and/or elected breast reconstruction in connection with the mastectomy. As long as the breast reconstruction is performed in a manner determined by the patient in consultation with the attending physician, benefits include:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Surgical Services

Coverage is provided for the following surgical services:

- Assistant Surgeon
- Bilateral Surgical Procedures
- Co-surgeon
- Multiple Surgical Procedures

Assistant Surgeon

Benefits may be provided for services of a physician who actively assists the operating surgeon when it is determined that the condition of the patient or the type of surgical service requires such assistance.

When considered necessary by the surgeon, the service of an assistant surgeon is a covered service. The benefit payable for the assistant surgeon's services is 20% of the benefit payable for the primary surgeon.

Bilateral Surgical Procedures

Bilateral surgical procedures are defined as more than one procedure associated with a single surgical event. For bilateral procedures, the plan considers 50% of the eligible benefit for the primary surgical procedure.

Co-Surgeon

A co-surgeon is usually a surgeon who is in the operating room performing a different surgery than the other surgeon who is present at the same time. Also, a co-surgeon is allowed in complicated surgeries (such as heart surgery) due to the length of time of the operation. The co-surgeons have the same responsibility. Co-surgeon services are covered at 50% of the eligible benefit of the surgeon's fee.

Multiple Surgical Procedures

For multiple surgeries (related operations or procedures performed through the same incision or in the same operative field, performed at the same operative session), the plan considers as an eligible expense 100% of the eligible surgical allowance for the highest paying procedure plus 50% of the eligible surgical allowance for the second highest paying procedure and 50% of the eligible surgical allowance for each additional procedure. For example, if the benefit normally pays 90%, the primary surgical procedure would be paid at 90%, the remaining surgical procedures would be paid at 50% of the 90% benefit.

Temporomandibular Joint Dysfunction (TMJ)

Coverage is provided for surgical treatment of temporomandibular joint dysfunction if due to accident, congenital defect or developmental defect. Appliances are limited to a $1,100 lifetime maximum.

Therapy Services

Coverage is provided for therapy services when used for the treatment of a condition, sickness or injury to promote the recovery of the covered person. To be covered, the therapy services must be rendered in accordance with a physician's written treatment plan.

Services covered under the Lumenos plan include:

- **Chemotherapy** – the treatment of malignant disease by chemical or biological antineoplastic agents. The cost of the antineoplastic agent is included.
- **Dialysis Treatment** – the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, to include hemodialysis or peritoneal dialysis.
- **Occupational Therapy** – the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the functional restoration of the person's abilities lost or impaired by disease or accidental injury, to satisfactorily accomplish the ordinary tasks of daily living. Occupational therapy is limited to 40 visits per person per Plan year.
- **Physical Therapy** – the treatment by physical means, hydrotherapy, heat, or similar modalities; physical agents; bio-mechanical and neuro-physical principles; and devices to relieve pain, restore maximum function lost or impaired by disease or accidental injury, and prevent disability following disease, injury or loss of body part. Physical therapy is limited to 40 visits per person per Plan year.
- **Radiation Therapy** – the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.
- **Respiratory Therapy** – the introduction of dry or moist gases into the lungs for treatment purposes.
- **Speech Therapy** - Speech therapy is covered to restore speech loss or correct impairment due to a congenital defect, illness or injury; such as stroke, head injury or vocal cord injury. Speech therapy is limited to 40 visits per person per Plan year.

Transplant Services

Coverage is provided for the expenses for human to human organ or tissue transplants including:

- Kidney
- Heart/lung
- Cornea
- Liver
- Bone marrow/Stem cell
- Pancreas
- Heart
- Lung
- Kidney/pancreas
- Liver/small bowel
- Small bowel

Covered expenses incurred by the donor of an organ or tissue for transplant to a recipient who is a covered person under this Plan are covered the same as any other sickness when the donor is a covered person under this Plan.

Covered expenses incurred by the donor of an organ or tissue for transplant when the donor is not a covered person under this Plan are covered to the extent of any benefits remaining after payment of the covered person's expenses as a recipient, when the donor's expenses

are not covered under any group or individual insurance policy or benefit plan and are charged to the recipient.

Covered expenses include:

- Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
- Services and supplies furnished by a facility provider;
- Treatment and surgery by a professional provider; and
- Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

Surgical, storage and transportation costs directly related to the procurement of an organ or tissue used in a transplant described above will be covered for each such procedure completed. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue. If a covered transplant procedure is not done as scheduled due to the intended recipient's medical condition or death, benefits will be paid for charges incurred for organ or tissue procurement as described above.

You must contact the plan in order for care to be precertified prior to services occurring. Benefits for transplants are limited to $500,000 lifetime maximum for all services other than kidney or cornea transplant.

Coverage is provided for transplant recipients and family members for the cost of travel and lodging. There is a combined episodic maximum of $10,000 per covered person. This maximum applies to all associated transportation, lodging and meal expenses incurred by the transplant recipient and companion(s). Benefits for transplant – transportation and lodging are covered at 100% of charges only when treatment is rendered in a facility that offers discounts.

The Lumenos plan covers the following expenses:

- Transportation for the patient and a companion traveling on the same day(s) to and/or from the site of the transplant for the evaluation, transplant procedure, or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not hospitalized) and companion. Benefits are paid at a rate of up to $50 per day for one person. If the patient is a dependent child, the transportation expenses of two companions will be covered, and lodging and meal expenses will be reimbursed up to $100 each day.
- Travel and lodging expenses – but only if the transplant recipient resides more than 50 miles from the designated transplant facility.

Maternity Care

Benefits are payable for pregnancy-related expenses of female employees or eligible spouses/dependents on the same basis as a covered illness. The expenses must be incurred while the person is covered under the Lumenos plan.

If you become pregnant, you are invited to enroll in the FutureFootsteps™ maternity program provided by FutureHealth. The Lumenos plan has important information to help you have a healthy pregnancy. Depending on your needs, a nurse will follow you throughout your pregnancy to provide support and help you carry out your doctor's instructions.

Also covered are services rendered in a birthing facility, provided that the physician in charge is acting within the scope of his license and the birthing facility meets all legal requirements; and midwife delivery services provided that the state in which such services are performed has legally recognized midwife delivery, and provided the midwife is licensed at the time delivery is performed.

NOTE: Home births are not covered, even if attended by a mid-wife.

Nursery facility charges for a baby will be covered under the enrolled mother until discharge from the nursery. Only charges for a nursery will be considered. Children admitted to or transferred to a more intensive level of care including, but not limited to, ICU, PICU, NICU are not covered under the Plan unless they are enrolled.

In order for any additional costs (including, but not limited to physician charges, labs, drugs) to be considered, the baby must be enrolled as per the Plan's enrollment and eligibility guidelines. No coverage exists until enrollment is completed.

Contact your payroll location to add the baby.

NOTE: Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health/Chemical Dependency

The Lumenos plan provides coverage for both mental health and chemical dependency care services. For mental health and chemical dependency services, the Lumenos plan pays 90% of discounted fees for providers who offer discounts or 60% Reasonable and Customary charges for providers who do not offer Discounts..

Services covered under your mental health and chemical dependency coverage include:

- Inpatient Mental Health and Chemical Dependency Confinement
- Outpatient Mental Health and Chemical Dependency Treatment

Inpatient and Residential Treatment Center Mental Health and Chemical Dependency Confinement

An acute inpatient hospitalization is described as treatment that includes 24-hour nursing and daily, active treatment under the direction of a psychiatrist, or for children and adolescents, a board certified/eligible child and adolescent psychiatrist.

Charges of a facility and/or professional provider related to or because of psychiatric illness are covered as follows:

- Inpatient facility charges;
- Individual Psychotherapy;
- Group Psychotherapy;
- Psychological Testing;

- Family Counseling (counseling with family members to assist in the covered person's diagnosis and treatment);
- Electro-Convulsive Therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional provider.

Benefits for mental health and chemical dependency inpatient confinement are limited to 30 days per person per Plan year combined on an aggregate basis.

Outpatient Mental Health and Chemical Dependency Treatment

Outpatient mental health treatment and chemical dependency treatment is described as the diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin. Care must be provided by a physician or licensed mental health/chemical dependency provider. Covered services include but are not limited to:

- Assessment
- Diagnosis
- Individual, group, family or conjoint psychotherapy,
- Medication management
- Psychological testing and assessment,
- Electroconvulsive treatment (ECT)
- Crisis intervention
- Rehabilitation (drug and alcohol related)

ECT, medication management, biofeedback treatments for mental health, and methadone maintenance treatments are covered under this benefit, but do not apply to the outpatient mental health/chemical dependency limits.

Outpatient services are limited to 30 visits per Plan year for individual and group therapy combined. The 30-visit maximum applies to outpatient mental health treatment and outpatient chemical dependency treatment *combined*.

Alternative Levels of Care

Alternative levels of care are covered as follows and apply toward annual inpatient day limits:

- **Acute Partial Hospitalization:** This is treatment that includes daily nursing and active treatment in a structured treatment program lasting 5-7 days per week and delivering at least 20 hours of active treatment per week, with patients going home each evening and/or weekend.
- **Intensive Outpatient Treatment (IOP):** IOP is a structured program that includes combinations of individual and group process therapy, meeting at least three times per week, and delivering at least 4 hours of treatment per week.

Hospital and Facility Services

This section provides a detailed description of the eligible hospital and facility services. Most services received from hospitals and facilities that offer discounts will be covered at 90% of discounted fees or 60% of charges for providers who do not offer discounts.

This section provides a detailed description of services covered under Traditional Health Coverage. To make it easier for you to find, the list of eligible services are listed in alphabetical order within the following categories:

- Emergency Room Care
- Emergency Room Care for Non-Emergencies
- Inpatient Medical Facility
- Inpatient Rehabilitation Facility
- Outpatient Facility
- Skilled Nursing Facility
- Urgent Care Center

Emergency Room Care

Facility and professional provider services and supplies for the initial treatment of traumatic bodily injuries resulting from an accident are covered.

Emergency medical care meeting the following definition is also covered: Facility and professional provider services and supplies for the initial treatment of a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- Permanently placing the covered person's health in jeopardy,
- Causing other serious medical consequences,
- Causing serious impairment to bodily functions, or
- Causing serious and permanent dysfunction of any bodily organ or part.

If the emergency room visit results in a hospital admission, you should notify the plan within 48 hours of the admission**.**

Emergency room care as described above will be reimbursed at 90% of discounted fees for providers who offer discounts and 90% of charges for providers who do not offer discounts.

Emergency Room Care for Non-Emergencies

Emergency room care for non-emergencies will be reimbursed at 60% of discounted fees for providers who offer discounts and 60% of charges for providers who do not offer discounts. Care for non-emergencies is defined as care received in an emergency room for a service or condition that does **not** meet the prudent layperson's assessment of emergency (see description above in Emergency Room Care section).

Inpatient Medical Facility

The Lumenos plan pays benefits toward the cost of the following types of inpatient hospital care services:

- Inpatient Room & Board
- Inpatient Ancillary Services

Inpatient Room and Board

Coverage provided for room and board is limited to the Semi-Private room rate. Private room, intensive care, coronary care and other specialized care units of a facility are covered when such special care or isolation is consistent with professional standards for the care of the patient's condition.

When room and board for other than Semi-Private care is at the convenience of the patient, payment will be made only for Semi-Private accommodations.

Inpatient Ancillary Charges

Coverage is provided for necessary services and supplies including, but not limited to admission fees, use of operating, delivery, and treatment rooms; prescribed drugs; whole blood, administration of blood, blood processing, and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced); anesthesia, anesthesia supplies and the administration of anesthesia by an employee of the facility; medical and surgical dressings, supplies, casts and splints; diagnostic services; and therapy services; but not services of a physician, or drugs or supplies not consumed or used in the facility.

Inpatient Rehabilitation Facility

Coverage is provided for Inpatient Rehabilitation Facilities. Most people who are admitted to an Inpatient Rehabilitation Facility are recovering from injuries or illnesses that severely impair their physical functioning or understanding. These include strokes, spinal cord injuries, traumatic brain injuries, chronic pulmonary problems, neurological disorders and other debilitating conditions.

Administered by treatment teams, individual patient programs can include these services:

- Behavioral medicine
- Case management
- Dialysis
- Nutrition services
- Neuropsychology
- Occupational therapy (OT)
- On-site orthotic and prosthetic services
- Physical therapy (PT)
- Psychology
- Recreation therapy
- Rehabilitation engineering and technology
- Rehabilitation nursing
- Social work
- Speech and language therapy
- Vocational and community re-entry services

Mental health/chemical dependency rehab is not covered under this benefit but rather under the MH/CD benefit.

Outpatient Facility

Outpatient facility charges are covered only when required for a covered service or procedure. Coverage is provided for necessary services and supplies including, but not limited to use of operating, delivery, and treatment rooms; prescribed drugs; whole blood, administration of blood, blood processing, and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced); anesthesia, anesthesia supplies and the administration of anesthesia by an employee of the facility; medical and surgical dressings, supplies, casts and splints; diagnostic services; and therapy services; but not services of a physician, or drugs or supplies not consumed or used in the facility.

Urgent Care Center

Coverage is provided at an emergency medical service center, which is separate from any other hospital or medical facility.

Services, Supplies, and Medical Expenses Not Covered

Certain services and supplies – and certain medical expenses – are not eligible for benefits under your Traditional Health Coverage. However, you may be able to cover some of these costs using your account.

The following is a list of services that are not covered under your Traditional Health Coverage:

- For adoption expenses;
- For any surgical technique performed for the correction of myopia or hyperopia, including but not limited to keratomileusis, keratophakia, or radial keratotomy (plastic surgeries on the cornea in lieu of eyeglasses), and all related services;
- For any treatment, confinement, or service which is not recommended by, or any operation which is not performed by, an appropriate professional provider;
- For appliances for vision correction such as eyeglasses and contact lenses;
- For autopsies;
- For breast pumps;
- For charges for enteral feeding formulas, except in the following situations:
    - Prescription and over the counter enteral feeding formulas when considered the sole source of nutrition and administered via a feeding tube. This includes tube feeding supplies; or
    - Oral prescription enteral formulas when considered the sole source of nutrition;
    - Over the counter low protein food supplements when prescribed by a physician as part of a treatment plan for PKU.

  Over the counter enteral feeding formulas are not covered when given orally, or are not the sole source of nutrition.
- For charges for equipment containing features of an aesthetic nature or features of a medical nature which are not required by the patient's condition;
- For charges for home births;
- For charges for sales tax;
- Charges for services for a member not eligible under the Lumenos plan at the time the service was rendered;
- For charges related to shipping and handling charges for any covered item;
- For the administration of the Flu Mist;
- For charges made for care or treatment which is not Medically Necessary (as determined by the Plan Administrator);
- For charges made which are in excess of the Reasonable and Customary charges (as determined by the Plan Administrator);
- For charges related to services or supplies for common household use, such as exercise cycles, air purifiers, air conditioners, water purifiers; allergenic mattresses; computer equipment and related devices, or supplies or a similar nature, whether or not prescribed by a physician;
- For charges the covered person has no obligation to pay;

- For cosmetic surgery, unless the covered person receives an injury which requires the surgery; or the cosmetic surgery is necessary to restore impaired bodily function resulting from disease, genetic abnormality, or previous therapeutic processes;
- For custodial care, domiciliary care or rest cures;
- For drugs and devices used for contraception, unless otherwise specified;
- For examination by a physician, related laboratory tests, x-rays and vaccines performed in the absence of specific symptoms on the part of the covered person (except as may be specifically provided herein);
- For examination or treatment ordered by a court in connection with legal proceedings will not be reimbursed;
- For expenses related to artificial reproductive procedures, including but not limited to artificial insemination and in vitro fertilization, or fertility drugs when used for treatment of infertility;
- For expenses related to exercise programs or use of exercise equipment, special diets or diet supplements,
- For expenses related to programs such as Nutri/System Program, Weight Watchers or physician supervised weight loss programs, or similar programs;
- For expenses related to treatment of nicotine addiction;
- For experimental or investigational procedures: Experimental or investigational procedures, drugs, or devices which the Plan Administrator determines are not generally recognized as being safe and effective by the medical community or ones that have not been approved by the FDA. The fact that an experimental or investigational service or an unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental or investigational or unproven in the treatment of that particular condition;
- For full body scans or EBCT (heart scans);
- For gene therapy as a treatment for inherited or acquired disorders;
- For injury sustained or sickness contracted as the result of or caused by any act of war, or participation in a riot or civil disobedience;
- For items purchased over the counter (with the exception of glucomoters and blood pressure monitors when deemed Medically Necessary by a provider, which would be considered covered);
- For learning disabilities or developmental delay treatment, services, educational testing or associated training;
- For liposuction;
- For marriage counseling, unless services billed contain a valid mental health diagnosis;
- For massage therapy not rendered by a physician;
- For non-medical counseling of training services;
- For non-surgical treatment of temporomandibular joint disorders and related conditions by any method;
- For or in connection with a sickness or injury for which you or your dependent is eligible or covered under Workers' Compensation or similar law;

- For or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit;
- For oral surgery or dental treatment except as may be specifically provided herein;
- For phototherapy devices related to seasonal affective disorder;
- For preservation of tissue or cells;
- For recreational or educational therapy or forms of non-medical self care or self-help training including health club memberships;
- For reversal of a sterilization procedures (i.e., vasectomy, tubal ligation);
- For routine physical exams and immunizations for employment, travel, summer camp or insurance purposes;
- For services provided without cost by any governmental agency, except where such exclusion is prohibited by law;
- For services rendered by a clergy;
- For services, treatment or supplies for which no charge would usually be made;
- For surrogate mother charges, unless the surrogate mother is eligible under the Lumenos plan at the time the services were rendered;
- For telephone consultations, charges for failure to keep a scheduled visit, charges for the copying of medical records, or charges for completion of a claim form;
- For the completion of any administrative forms;
- For extraction of wisdom teeth;
- For the services performed by any person who is a member of the covered person's immediate family consisting of the covered person, spouse, child(ren), brothers, sisters or parents or a family member who resides in the covered person's home;
- For transgender surgery;
- For treatment of sexual dysfunction not related to organic disease;
- For vision exams;
- For vitamins, except those which by law require a prescription order and are prescribed to treat a specific sickness or injury, or nutritional supplements;
- For vocational, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-Medically Necessary education, except as specifically provided in this Plan;
- To the extent that you or your dependent is reimbursed or in any way indemnified for those expenses by or through Medicare or any other public program;
- For acupuncture services;
- For hearing aids;
- For immunizations for travel;
- For naturopathic services;
- For nutritional counseling;
- For orthopedic shoes except when an integral part of a brace;
- For preventive care services rendered by providers who do not offer discounts;
- For residential treatment facilities;
- For skilled nursing facilities;

- For weight reduction (i.e. gastric bypass, gastric plication, lap-band) surgeries;
- For wigs;
- For any other service or supply except as specifically provided herein.

The Plan sponsor continues to reserve its discretion to exclude other procedures relating to charges for any condition, disease, ailment or illness which are not deemed to be medically necessary, reasonable or otherwise covered. Thus, no inference should be drawn from the inclusion or exclusion of any specific condition, disease, ailment or illness, or its related treatment, diagnosis or care, in this section or otherwise.

Prescription Drug Benefits

Prescription drug coverage is provided for Medically Necessary outpatient prescription drugs and supplies for pregnancy or the treatment of an accidental injury or sickness. You or your dependent must be covered at the time the prescription or refill is filled. For more information, see:

- Pharmacy Benefits
- Eligible Prescription Drugs
- Drugs Not Covered

Pharmacy Benefits

The Lumenos plan contracts with a number of retail pharmacies and a mail order pharmacy that offers a discount on prescription drugs. For a list of participating pharmacies, contact Customer Service at (866) 835-6863.

Under the Lumenos plan, your pharmacy costs will be based on where you are within your benefit plan. While you have money in the account, you will not pay for any covered prescription drugs at the pharmacy. The cost of the prescription will be deducted from your account. When you are in the Bridge, you will need to pay the discounted cost of the covered drug. Once you reach the Traditional Health Coverage, you will pay 10% if you purchase prescription drugs at a pharmacy that offers discounts. When you receive your prescription from a pharmacy, you are able to get up to a 30-day supply. If you visit a pharmacy that does not offer discounts, you will have to pay the full price at the time of service, then file a claim for reimbursement. You will be reimbursed based on where you are within your benefit plan. Under your Traditional Health Coverage, you will be responsible for coinsurance, as well as the difference between the billed charges and Reasonable and Customary charges.

Eligible Prescription Drugs

Federal Legend Drugs that are not specified below will be considered eligible for reimbursement.

Drugs Not Covered

The following prescription drugs are not covered:

- Non-Federal Legend Drugs
- OTC Contraceptive jellies, creams, foams, devices
- Injectable Medications (except those listed above)
- Fertility Agents (except those listed above)
- Lupron® (except Lupron 1 mg)
- Synarel®
- Factrel®, Lutrepulse
- Smoking Deterrents
- Growth Hormones

- Anti-Obesity Preparations
- Dental Fluoride Products
- Homeopathics
- Vitamins (except those listed above)
- Retin-A®/Avita® age 30 and over
- Differin® age 30 and over
- Accutane® age 30 and over
- Ostomy Supplies
- Yohimbine®
- Mifeprex®
- Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.
- Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.

For questions regarding coverage for specific drugs, contact Customer Service at (866) 835-6863.

Claims and Appeals

To receive a claim for benefits from the Lumenos plan, follow the procedures for filing claims and appealing claims.

Filing Claims

If you receive services from a provider who offers a discount, your provider should submit the claim for reimbursement, on your behalf. If you receive services from a provider who does not offer a discount you must file your own claim. If you need to file your own form, it's a good idea to take the form along with you when you see your provider. You can obtain a member claim form either from your employer's benefit office, by contacting Customer Service at (866) 835-6863 or by logging in to www.lumenos.com under My Benefits – Forms Library.

When you need to file a claim for benefits, complete the appropriate forms and mail them with all required documentation to the Claims Administrator at:

Lumenos
P.O. Box 69309
Harrisburg, PA 17106-9309

NOTE: When services are rendered by a provider who offers a discount, claims should be submitted by the provider to the address denoted on your identification card.

IMPORTANT! Claims should be submitted as soon as possible. Claims submitted more than 6 months from the date of service for claims where Lumenos is primary will not be honored. Claims submitted more than 12 months from the date of service for claims where Lumenos is secondary will not be honored. Previous Plan year HRA claims will be applied against your previous Plan year HRA funds and never against current Plan year funds. Current Plan year claims will be applied against previous Plan year HRA funds but only after you have used all your current Plan year HRA funds.

NOTE! If you are covered under the Lumenos plan and a health FSA maintained by your employer, expenses covered both by the HRA and the Health FSA must be paid first from the HRA. Charges not reimbursed, such as Bridge amounts and coinsurance, may be eligible for reimbursement from an employer-sponsored flexible spending account if they are not reimbursable from any other source.

Generally, the company has delegated its claims administration authority for the Lumenos plan to Lumenos. As the Claims Administrator, Lumenos is responsible for reviewing and processing certain claims, as follows:

- Initial benefit determinations
- First level appeals,
- Second level appeals, and
- All appeals involving urgent care.

Benefit Determinations

There are four types of Plan claims: Pre-Service, Concurrent Care, Urgent Care Claims and Post Service Claims.

Pre-Service Claim—a claim for health care where prior approval for any part of the care is a condition to receiving the care. For example, the Plan requires that you pre-certify hospital admissions.

Concurrent Care Claim—a previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments.

Post-Service Claim—a claim for care that has already been received and, any claim for which the Plan does not require pre-authorization.

Urgent Care Claim—a Pre-Service or Concurrent Care Claim becomes an Urgent Care Claim when the normal time frame for making a determination would:

- seriously jeopardize the life of the claimant (in the view of a prudent lay person acting on behalf of the Plan who possesses an average knowledge of health and medicine or a physician with knowledge of the claimant's medical condition) or
- subject the claimant to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the claimant's condition).

Claims Review and Appeals Procedures

Step 1: *Notice is received from Claims Administrator.* If your claim is denied, you will receive written notice from the Claims Administrator that your claim is denied (in the case of urgent claims, notice may be oral). The time frame in which you will receive this notice is described in the chart below and will vary depending on the type of claim. In addition, the Claims Administrator may obtain an extension of time in which to review your claim if necessary for reasons beyond the Claims Administrator's control. If the reason for the extension is that you need to provide additional information, you will be given a certain amount of time in which to obtain the requested information (it will vary depending on the type of claim). The time period during which the Claims Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the applicable information gathering period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Claims Administrator, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following a denial of your appeal;
- a statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and that a copy of that rule, guideline or protocol will be provided free of charge upon request;
- if the denial is based on a medical necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request; and

- if the claim was an Urgent Care Claim, a description of the expedited appeal process. The notice may be provided to you orally; however, a written or electronic notification will be sent to you not later than three days after the oral notification.

Step 3: *If you disagree with the decision, file a 1st Level Appeal with the Claims Administrator.* If you do not agree with the decision of the Claims Administrator, you may file a written appeal with the Claims Administrator within 180 days of receipt of the Claims Administrator's letter (or oral notice if an urgent care claim) referenced in Step 1. If the claim involves urgent care, your appeal may be made orally. In addition, you should submit all information identified as necessary to perfect your claim that is referenced in the Notice described in Step 2 with your appeal. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim. Your request for appeal must include the following:

- the patient's name and identification number
- the date of the medical service
- the provider's name
- the reason you believe the claim should be paid, and
- any documentation or other written information to support your request for claim payment.

All appeals will be processed as described below.

All appeals should be sent to:
Lumenos
1801 North Beauregard Street, Suite 10
Alexandria, Virginia 22311-1701
Attention: Appeals Department

Step 4: *1st Level Appeal notice is received from Claims Administrator.* If the claim is again denied, you will be notified by the Claims Administrator within the time period described in the chart below depending on the type of claim.

Step 5: *Review your notice carefully*. You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Claims Administrator.

Step 6: *If you still disagree with the Claims Administrator's decision, file a 2nd Level Appeal with the Claims fiduciary.* If you still do not agree with the Claims Administrator's decision, you may file a written appeal to the Claims fiduciary within 60 days after receiving the first level appeal denial notice from the Claims Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim. The appeal should be sent to:

Lumenos
1801 North Beauregard Street, Suite 10
Alexandria, Virginia 22311-1701
Attention: Appeals Department

If the Claims fiduciary denies your 2nd Level Appeal, you will receive notice within the time period described in the chart below, depending on the type of claim. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e. the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- If an appeal involves medical judgment, then the Claims Administrator and the Claims fiduciary will consult during the 1st and 2nd level appeals with an independent health care professional who has expertise in the specific area involving medical judgment.
- While it is your option to appeal, you cannot file suit in federal court until you have exhausted these appeals procedures.

This chart shows the time limit for you to submit appeals and the time for the claims reviewer to respond. This chart is intended to be used in conjunction with the remainder of information in this section.

Type of Claim	Initial Claims			1st Level Appeal		2nd Level Appeal	
	Claimant must be notified of determination as soon as possible but no later than…	**Extension period allowed for circumstances beyond claims administrator's control…**	**If additional information is needed, claimant must provide information within…**	**Claimant must file appeal within…**	**Claimant will be notified of determination as soon as possible but no later than…**	**Claimant must file appeal within…**	**Claimant will be notified of determination as soon as possible but no later than…**
Group Health Benefit Plans							
Pre-Service	15 days from receipt of claim	one extension of 15 days	45 days after date of extension notice	180 days of receipt of adverse benefit determination	15 days of receipt of appeal (no extensions)	60 days after receipt of determination letter.	15 days from receipt of appeal (no extensions)
Pre-Service involving Urgent Care	72 hours (must notify claimant within 24 hours if additional information is needed from claimant)	The claimant will be allowed 48 hours to provide requested information	At least 48 hours. Claims administrator must notify claimant of determination within 48 hours of receipt of claimant's information or end of 48 hour period, whichever is earlier.	180 days upon receipt of adverse benefit determination	72 hours of receipt of appeal	Urgent Care claims limited to 1 level of appeal.	N/A
Concurrent: To end or reduce treatment prematurely	Claims Administrator must notify claimant of the decision to reduce or terminate sufficiently in advance of the end date in order to allow the claimant to appeal	None. Decision to reduce or terminate benefit has already been made. The next step for the claimant is to appeal.	None	The determination letter will identify the applicable time period.	15 days of receipt of appeal (no extensions)	The determination letter will identify the applicable time period.	15 days from receipt of appeal (no extensions)

Type of Claim	Initial Claims			1st Level Appeal		2nd Level Appeal	
	Claimant must be notified of determination as soon as possible but no later than…	**Extension period allowed for circumstances beyond claims administrator's control…**	**If additional information is needed, claimant must provide information within…**	**Claimant must file appeal within…**	**Claimant will be notified of determination as soon as possible but no later than…**	**Claimant must file appeal within…**	**Claimant will be notified of determination as soon as possible but no later than…**
Concurrent: To deny your request to extend treatment	Treated as any other pre-service or post service claim.	Treated as any other pre-service or post service claim.	Treated as any other pre-service or post service claim.	Treated as any other pre-service or post service claim.	Treated as any other pre-service or post service claim.	Treated as any other pre-service or post service claim.	Treated as any other pre-service or post service claim.
Concurrent involving Urgent Care	24 hours, if claimant's request is made at least 24 hours before the date treatment is scheduled to end. Otherwise, request is treated as "Pre-Service Urgent Care" claim	None	N/A	180 days upon receipt of adverse benefit determination.	72 hours of receipt of appeal	Urgent Care claims limited to 1 level of appeal.	N/A
Post-Service	30 days from receipt of claim	one extension of 15 days	45 days after date of extension notice	180 days upon receipt of adverse benefit determination.	30 days of receipt of appeal (no extensions)	60 days after receipt of determination letter	30 days from receipt of appeal (no extensions)

Leaving the Plan

You have certain rights as a Lumenos plan participant when you leave the Lumenos plan.

- When Coverage Ends
- Certificate of Coverage
- Coverage Under Special Circumstances
- Right to Purchase Continuing Coverage

When Coverage Ends

Benefit coverage for you under the Plan and the Lumenos plan option will end when the earliest of the following occurs:

- the State Health Benefit Plan discontinues the Plan
- the Plan is amended to exclude the specific group of employees of which you are a member
- you reach the individual maximum lifetime benefit under the Plan
- you fail to make required contributions for coverage
- you terminate employment with the company for any reason
- you cease to be an eligible employee

NOTE: If your participation in the Lumenos plan ends for any reason, any balance in your account will be forfeited back to the company.

Your dependents' coverage under the Plan will end when the earliest of the following occurs

- the State Health Benefit Plan discontinues the Plan
- they no longer qualify as dependents under the Plan
- your coverage ends for any reason
- the Plan is amended to exclude the specific group of dependents to which they belong
- they reach the individual maximum lifetime benefit under the Plan
- you (or your dependent) fail to make required contributions for coverage
- any other disqualifications for benefits

Under certain circumstances, you and your covered dependents may be eligible to purchase continuing coverage for a limited time.

Certificate of Coverage

When your coverage under the Lumenos plan ends, you will receive a certificate of group health plan coverage on behalf of your employer. You may take this certificate to another health care plan to receive credit for your coverage with the company. You will only need to do this if the other health care plan has a pre-existing condition limit. Coverage under the Plan will not be considered by another plan if the coverage is followed by a break in coverage of 63 days or more.

Coverage Under Special Circumstances

Under certain circumstances, even if you are not employed, you may be able to continue coverage under the Plan. Your account will continue to be available to you while you are covered during these circumstances.

For more information, see:

- If You Take a Military Leave of Absence
- If You Take a Family Medical Leave Absence (FMLA)

If You Take a Military Leave of Absence

If you are on a military leave of absence under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you and your dependents may continue to receive medical benefits under the Plan for a limited period of time, as long as you pay any required premiums (See the COBRA section for information concerning your rights and obligations to continued coverage).

You will receive benefits during your USERRA leave until the earlier of the following:

- the day after the date your leave ends, if you fail to return to employment
- 24 months from the date your USERRA leave began.

During your USERRA leave, you can pay your contributions for medical coverage on a monthly basis to the company. If your length of USERRA leave is less than 31 days, then your contribution amount will be the same as the active employee rate. However, if your length of leave is 31 days or longer, then your contribution amount will be up to 102% of the cost of your coverage.

If You Take a Family Medical Leave Absence (FMLA)

If the company grants you an approved FMLA leave, coverage continues during your approved leave as long as you continue to pay your required contributions. If you take paid FMLA leave, your premiums continue to be taken out of your paycheck. If you take unpaid FMLA leave, you can prepay your premiums or remit payment on an after-tax monthly basis.

Coverage will **not** continue beyond the earliest date on which:

- you fail to make any required contribution
- the company determines your approved FMLA leave is terminated
- you are no longer eligible for coverage.

If you return to active employment after your FMLA leave is over and didn't maintain your coverage during the leave, your coverage can be resumed with no waiting period. However, you must make a request for this coverage within 31 days of when the company determined your leave was over. If you do not make this request within 31 days, coverage is not available until the next open enrollment period.

Right to Continuation Coverage

You have the right to COBRA continuation coverage if you lose coverage under the Plan as a result of a termination of employment (for reasons other than gross misconduct) or a reduction in your hours of employment.

Your spouse has the right to COBRA continuation coverage under the Plan if your spouse loses coverage under the Plan as a result of any one of the following four events:

- you terminate employment (for reasons other than gross misconduct) or have a reduction in your hours of employment (including a military leave of absence)
- you die
- you and your spouse divorce or legally separate
- you become entitled to Medicare

Your covered dependent children may have the right to COBRA continuation coverage under the Lumenos plan if your dependent children lose coverage as a result of any one of the following five events:

- you terminate employment or have a reduction in your hours of employment
- you die
- you and your spouse divorce or legally separate
- you become entitled to Medicare
- your dependent child ceases to be an eligible dependent under the Plan

These events that result in a loss of coverage are called "qualifying events." You, your covered spouse, and your covered dependents that are covered immediately preceding the qualifying event are called "qualified beneficiaries". A child born to or adopted by (including a child placed for adoption with) a covered employee during the covered employee's COBRA period is also considered a "qualified beneficiary" if properly enrolled.

Notice and Election Rules

The Plan Administrator must send notice to qualified beneficiaries of the right to the continuing participation following the covered employee's termination of employment, reduction in hours or death.

If the covered spouse and/or covered dependent children lose coverage as a result of a divorce, legal separation, or dependent child ceasing to be a dependent, you or the affected qualified beneficiary must send notice to the Plan Administrator within 60 days of the latter of the event or the date coverage is lost as a result of such event. The Qualified Beneficiary will then be sent a notice of this right to continuing participation following receipt of your notice.

Once you and/or any other qualified beneficiary have been provided notice of the right to elect COBRA continuation coverage, an election for continuation coverage under the Plan must be made within 60 days of the later of the date of the notice or the date coverage is lost as a result of the qualifying event. If a qualified beneficiary fails to provide this notice to the Plan Administrator during this 60-day notice period, the qualified beneficiary will lose the right to COBRA continuation coverage and coverage under the Plan will cease as of the last date the dependent was eligible for coverage. Each qualified beneficiary has a separate and independent right to elect COBRA continuation coverage. A qualified beneficiary employee or spouse can elect coverage for any other qualified beneficiary. On the other hand, you may not decline COBRA continuation coverage for the qualified beneficiary spouse. A parent or guardian can elect coverage for a qualified beneficiary child who is a minor.

Coverage That May Be Continued

Generally, a qualified beneficiary is entitled to the same coverage that the qualified beneficiary had immediately preceding the qualifying event, which includes any tier or level of coverage included within that pre-qualifying event coverage that may apply. Thus, if you had family coverage prior to a termination of employment, you may elect to continue family coverage for yourself and other qualified beneficiaries, or you may elect single coverage for yourself if your qualified beneficiary family members decline COBRA coverage. Likewise, a divorced spouse (or dependent child ceasing to be eligible) would be entitled to elect single Traditional Health coverage.

Once a qualified beneficiary elects coverage, the qualified beneficiary is subject to the same annual limits (e.g. Bridge limits and out of pocket maximums) that apply to the tier of coverage elected by the qualified beneficiary. For example, if the qualified beneficiary elects single COBRA continuation coverage, the qualified beneficiary is subject to Bridge limits and the out of pocket maximums applicable to single coverage under the Lumenos plan. Also, all of the qualified beneficiary's expenses credited towards Lumenos plan limits prior to the qualifying event will be credited towards the annual Lumenos plan limits applicable to the COBRA continuation coverage elected by the qualified beneficiary for the remainder of the Plan year.

Special Rule for HRAs

A qualified beneficiary may continue the level of coverage in effect under the HRA immediately preceding the qualifying event for the remainder of the Plan year, even if the qualified beneficiary elects a lower tier of coverage. When a subsequent Plan year begins, the qualified beneficiary, family unit (or if no family unit, the single qualified beneficiary) will be entitled to any unused amounts from the previous Plan year plus an increase in the HRA coverage level equal to the Employer contribution applicable to the coverage tier elected by the qualified beneficiary.

Example: Employee A and spouse B are covered by the Lumenos plan. On March 31, employee A and spouse B have $1,000 available for reimbursement under the HRA. On April 1, employee A dies. Spouse B elects single level coverage and the HRA. Under the HRA, the spouse may continue the $1,000 HRA through the remainder of the year (reduced by expenses paid from the HRA through the end of the year). On the following January 1, spouse B will be entitled to any unused amount from the previous year and an increase in HRA coverage equal to the company contribution for single coverage.

Changing COBRA Coverage

The COBRA coverage that you and/or your qualified beneficiaries elect may be changed in the following situations:

- if the company modifies the Plan and that modification applies to all active employees who have the same tier of Plan coverage as the qualified beneficiary, then coverage for the qualified beneficiary will be modified in the same way
- qualified beneficiaries may make changes to COBRA coverage during open enrollment
- qualified beneficiaries can make the same changes to coverage during the Plan year that active employees can make.

Duration of Coverage

Qualified beneficiaries may continue coverage for 18 months if you lose group health coverage because of a termination of employment (for reasons other than gross misconduct) or your coverage ends because of a reduction in hours of employment. Qualified beneficiaries other than the covered employee may continue coverage under the Plan for 36 months if coverage is lost as a result of the covered employee's death, a divorce or legal separation or a dependent child/domestic partner ceasing to be a dependent, or you become entitled to Medicare.

If you or a qualified beneficiary family member is determined by the Social Security Administration to have been disabled at any time prior to the end of the first 60 days of continuation coverage, COBRA may be extended from 18 months up to 29 months. You or a qualified beneficiary must notify the Plan Administrator prior to the end of the end of the original COBRA period (up to 18 months) or the 60-day notice period, whichever comes first. The 60 day notice period ends 60 days after the latter of:

i) the date of the determination,

ii) the date of the qualifying event (i.e. termination of employment)

iii) the date that coverage is lost as a result of the qualifying event or

iv) the date that a qualified beneficiary is notified through this SPD or the General Notice of the obligation to provide notice.

If the Social Security Administration determines that you or a qualified beneficiary is no longer disabled while on COBRA continuation coverage, you or a qualified beneficiary must notify the Plan Administrator within 30 days of the date the Social Security Administration's determination that you are no longer disabled.

If you become entitled to Medicare (and don't lose coverage under the Plan) and then terminate employment or have a reduction in hours of employment within 18 months of your Medicare entitlement, your qualified beneficiary spouse and/or covered children/domestic partner are eligible to receive 36 months of continuation coverage beginning on the Medicare entitlement date.

If COBRA coverage was elected following a termination of employment or reduction in hours of employment, additional qualifying events (such as divorce, Medicare entitlement, or death) may occur during the first 18 months (or during the disability extension discussed above) that may result in an extension of the 18-month (or 29 month) continuation period to 36 months for your covered spouse and dependents. In no event will COBRA continuation coverage last longer than 36 months from the date of the termination of employment or reduction in hours of employment. You or your qualified beneficiary must notify the Plan Administrator if a second qualifying event occurs during your continuation coverage period.

Early Termination of Coverage

Your continuation coverage will end prior to the expiration of the 18-, 29-, or 36-month period for any of the following reasons:

- the company no longer provides group health coverage to any of its employees
- the qualified beneficiary does not make the required payments (within the grace period)
- you or a qualified beneficiary on COBRA becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that

does not contain any applicable exclusion or limitation with respect to any pre-existing condition of the individual

- you or a qualified beneficiary on COBRA becomes entitled to Medicare after the date COBRA is elected (this does not apply during the 1st 18 months of continuation coverage due to a military leave of absence)
- coverage has been extended for up to 29 months due to qualified beneficiary's disability and there has been a final determination that the qualified beneficiary is no longer disabled on the 29 month period is exhausted

Cost of Coverage

Under federal law, you are required to pay 102% of the cost for your continuation coverage (which is equal to the cost to the Plan to provide the tier of traditional coverage that you elect and the HRA coverage level that you continue). If your coverage extends from 18 to 29 months due to a qualifying disability, you may be required to pay 150% of the cost starting on the 19th month of continuation coverage. The cost of coverage under the Plan periodically changes. If you elect continuation coverage, the company will notify you of any changes in the cost.

The initial payment for continuation coverage is due 45 days from the date of your COBRA election. This initial payment must cover the period through the end of the month preceding the month in which the initial premium deadline falls. Thereafter, you must pay for coverage on a monthly basis for which you have a grace period of at least 30 days. Payment is due (without the grace period) at the first of the month.

If you have any questions about your rights under COBRA, contact your personnel/payroll office

IMPORTANT! The Claims Administrator is not a continuing coverage administrator. It is not responsible for any notifications, billings or collections. The Claims Administrator will continue to process claims for members covered by the continuing coverage provisions.

IMPORTANT! Special rules apply to continuation of coverage under USERRA. The Plan will be administered in accordance with both COBRA and USERRA.

Third Party Liability

In certain situations your benefits under the Plan and the Lumenos plan option will be coordinated with other benefits. Refer to the sections below for additional information:

- Coordination of Benefits (COB)
- Integrating Benefits with Medicare
- Subrogation

Coordination of Benefits (COB)

If you are eligible for benefits under another group health care plan, such as your spouse's plan or another employer's plan, the two plans will coordinate their benefit payments so the combined payments do not exceed your actual expenses. This provision is called coordination of benefits (COB). The Plan uses a COB method called "non-duplication of benefits."

For more information on COB, see:

- How COB Works
- COB "Birthday Rule"
- Right to Recover

How COB Works

Under COB provisions, one group plan has "primary" responsibility and pays first. The other group plan has "secondary" responsibility and considers any additional benefits not covered by the primary carrier. Therefore, if the Plan is:

- *primary* – it pays expenses as if no other insurance were involved
- *secondary* – it pays benefits only if you have not already received the full amount the Plan would pay if it were primary

if the benefit is for …	Then …
You	The Plan is primary for you, as an employee
You as a COBRA participant continuing benefits under another plan	COBRA coverage will be primary for limits and exclusions under the other plan
Your spouse	The Plan is always the secondary payer if he or she is covered through another employer's plan
Your dependent children	The primary plan for your dependent children is determined by the COB "Birthday Rule" except where child is covered as an employee under another employer plan. In that case, the plan covering the dependent as an employee will be primary (without regard to the Birthday Rule)

If the other group benefit plan does not have a COB provision, these rules will not apply. In that case, the other group plan is automatically primary.

You should always file a claim with the primary plan first and then submit a copy of what the primary plan has paid or denied (along with copies of the same itemized expenses) to the

secondary plan. This will avoid delays in claims processing and will ensure that you are reimbursed for the full amount to which you are entitled.

COB "Birthday Rule"

Under this rule, primary coverage for your dependent children will be the plan of the parent whose *birthday* occurs first in the calendar year. For example, if your spouse's birthday is in March and your birthday is in October, your spouse's plan will provide primary coverage for your children. If a decision cannot be made based on the birthday rule, the plan that has covered the individual the longest will be primary.

Primary coverage for a dependent child whose parents are separated or divorced will be determined in the following order, without regard to the birthday rule:

1. The plan of the parent with custody of the child.
2. The plan of the stepparent whose spouse has custody of the child – if the parent with custody has remarried.
3. The plan of the parent not having custody of the child.

NOTE: If a court decree declares one parent responsible for a child's health care expenses, payment will be made first under that parent's plan.

Right to Recover

If the Plan makes larger payments than are necessary under this COB provision or under any other provision, the Plan Administrator has the right to recover the excess payments from any insurance company, any organization, and/or any persons for whom those payments were made.

The Claims Administrator also may pay another organization an amount that it determines is warranted, if the other organization or group plan pays benefits that should have been paid under the Plan.

The Plan also has the right to receive and release necessary information to determine whether coordination of benefits or any similar provisions apply to a claim. By participating in this Lumenos plan option, you agree to furnish any information that the Plan Administrator requires in order to enforce these provisions.

Integrating Benefits with Medicare

As a general rule, if you or your covered dependent becomes eligible for Medicare benefits, there are rules that determine whether the Plan pays benefits first, or whether Medicare is primary.

If you are an active employee covered by the Plan, the Plan would be primary for you and your covered dependent who is entitled to Medicare (for example, due to a disability or being age 65 or older). If you are disabled and not actively working, the Plan would be primary for you and any covered dependents who may be entitled to Medicare for the first six calendar months of your disability period. After the six-month period, if you are not actively working at the Company, Medicare pays benefits first for you and any covered dependents (if they are also eligible for Medicare).

During the time the Plan pays benefits first, you should submit a claim for any remaining expenses not covered by the Plan to Medicare. (Incidentally, you should apply for Social

Security disability income benefits during the fifth month of disability to make sure you have no gaps in income protection.) During the time Medicare pays benefits first, you should first submit claims to Medicare for payment.

Medical Coverage for Individuals with End-Stage Renal Disease

In all situations involving end-stage renal disease (ESRD) – regardless of age or Medicare status – the Plan will be the primary payer of medical benefits during the first 30 months the individual is eligible for Medicare benefits as a result of End Stage Renal Disease. Thereafter, Medicare will be the primary payer of medical benefits for the individual and the Plan will be secondary payer.

Subrogation/Right of Recovery

This section describes the Plan's right to seek reimbursement of expenses that are paid by the Lumenos plan on behalf of you or your covered dependents (referred to in this section as a "Covered Individual") if those expenses are related to the acts of a third party (for example, if you are involved in an automobile accident). The Plan Administrator may seek reimbursement of these expenses on behalf of the Plan from any recovery you may receive from the third party or another source, including from any insurance proceeds, settlement amounts or amounts recovered in a lawsuit. The terms of the Plan's reimbursement rights are described below:

- If a Covered Individual incurs expenses covered by the Plan as a result of the act of a third party (person or entity) you may receive benefits pursuant to the terms of the Plan. However, the Covered Individual shall be required to refund to the Plan all benefits paid if the Covered Individual recovers from any other party (such as proceeds from a settlement, judgment, lawsuit or otherwise as a result of the act). The Covered Individual may be required to:
- Execute an agreement provided by the Plan Administrator or the Claims Administrator acknowledging the Plan's right of recovery, agreeing to repay any claims paid by the Plan, pledging amounts recovered by the Covered Individual from the third party as security for repayment of any claims paid by the Plan, and to the extent provided below, assigning the Covered Individual's cause of action or other right of recovery to the Plan. If the Covered Individual fails to execute such an agreement, by filing claims (assigning benefits or having claims filed on your behalf) related to such act of a third party, the Covered Individual shall be deemed to agree to the terms of this reimbursement provision;
- Provide such information that the Plan Administrator and/or the Claims Administrator may request;
- Notify the Plan Administrator or Claims Administrator in writing by copy of the complaint or other pleading of the commencement of any action by the Covered Individual to recover damages from a third party;
- Agree to notify the Plan Administrator or Claims Administrator of any recovery.

The Plan's right to recover the benefits it has paid is subject to reduction for attorney's fees or other expenses of recovery. The reduction is limited to the lesser of the actual attorney fees and other expenses or one-third of the Plan's lien. The Plan's right of recovery shall apply to the entire proceeds of any recovery by the Covered Individual. This includes any recovery by judgment, settlement, arbitration award or otherwise. The Plan's right to recover shall not be limited by application of any statutory or common law "make whole" doctrine (i.e., the Plan has a right of first reimbursement out of any recovery, even if the Covered

Individual is not fully compensated) or the characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained.

The Plan shall have a lien against the proceeds of any recovery by the Covered Individual and against future benefits due under the Plan in the amount of any claims paid. The lien will attach as soon as any person or entity agrees to pay to or on behalf of a Covered Individual that would otherwise be subject to the Plan's right of recovery. If the Covered Individual fails to repay the Plan from the proceeds of any recovery, the Plan Administrator may satisfy the lien by deducting the amount from future claims otherwise payable under the Plan.

If the Covered Individual fails to take action against a responsible third party to recover damages within one year or within 30 days after the Plan requests, the Plan shall be deemed to have acquired, by assignment or subrogation, a portion of the Covered Individual's claim equal to the amounts the Plan has paid on the Covered Individual's behalf. The Plan may thereafter commence proceedings directly against any responsible third party. The Plan shall not be deemed to waive its rights to commence action against a third party if it fails to act after the expiration of one year nor shall the Plan's failure to act be deemed a waiver or discharge of the lien described above.

The Covered Individual shall cooperate fully with the Plan in asserting claims against a responsible third party and such cooperation shall include, where requested, the filing of suit by the Covered Individual against a responsible third party and the giving of testimony in any action filed by the Plan. If a Covered Individual fails or refuses to cooperate in connection with the assertion of claims against a responsible third party, the Plan Administrator may deny payment of claims and treat prior claims paid as overpayments recoverable by offset against future Plan benefits or by other action of the Plan Administrator.

In addition, the Plan has a right to recover benefits that were paid in error (e.g., benefits paid to an ineligible person) or benefits that were obtained in a fraudulent manner, as determined by the Plan Administrator. Benefits may be recovered by either direct payment to the Plan by you or a beneficiary (through voluntary payments or legal action) or by an offset of future benefits equal to the amount of the overpayment.

Other Plan Information

Refer to the following sections for other Plan information:

- Payment Due to Incompetency
- Amendment to or Termination of the Plan or Lumenos plan Option
- Other Documents

Payment Due to Incompetency

If a person entitled to receive benefits under the Plan is legally, physically or mentally incapable of receiving benefits, the Plan Administrator may make payment to another person or institution determined to maintain or have custody of the individual.

Amendment to or Termination of the Plan or Lumenos Plan Option

Although the company expects and intends to continue the Plan and the Lumenos plan option indefinitely, it may change or end the Plan and/or Lumenos plan option at any time for any

reason. If the Plan or Lumenos plan option is changed or ends, you may not receive benefits as described here. However, you may be entitled to receive different benefits, or benefits under different conditions. The benefits under this plan do not vest.

Other Documents

To the extent that this Summary Plan Description (SPD) summarizes the plan documents governing the plan, if the SPD conflicts with the plan documents, the plan documents will control.

Plan Administration

The Lumenos plan is an option under the State Health Benefit Plan. The State Health Benefit Plan is the sponsor of the Plan. You and the company pay for the cost of the Plan. The company has delegated certain responsibilities of the Plan Administrator to the Claims Administrator. The Claims Administrator is not responsible for funding the payment of any benefits.

For important administrative information about the Plan and your rights as a Plan participant, see:

- Use of Health Information
- Plan Information

Use of Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. This means that the Plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operation, or Plan administration, or as required or permitted by law. A description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the Plan's notice of privacy practices, which has been furnished to you, which is incorporated herein by reference. You may obtain a copy of the Plan's notice of privacy practices by contacting your personnel/payroll office.

Plan Information

Refer to the following for important administrative information about the:

- Plan Name/Number
- Plan Sponsor/Employer Identification Number (EIN)
- Plan Administrator
- Agent for Legal Process
- Future of the Plan
- Plan Type
- Source of Funding
- Plan year
- Claims Administrator

- Claims Fiduciary

Plan Name/Number

The Plan name is the **State Health Benefit Plan**. The Lumenos plan is an option under the Plan.

Plan Sponsor/Employer Identification Number (EIN)

The State Health Benefit Plan is the sponsor of the Plan under which the Lumenos plan is an option.

The Plan sponsor's EIN is 58-1282972

Plan Administrator

The Plan Administrator is:

State Health Benefit Plan
PO Box 38342
Atlanta, GA 30334

(800) 610-1863

Except as otherwise provided herein (see "Claims Fiduciary" below) the Plan Administrator has the exclusive right and discretion to interpret the terms and conditions of the Plan, and to decide all matters arising in its administration and operation, including questions of fact and issues pertaining to eligibility for, and the amount of, benefits to be paid by the Plans. Any such interpretation or decision shall, subject to the claims procedure described herein, be conclusive and binding on all interested persons, and shall, consistent with the Plans' terms and conditions, be applied in a uniform manner to all similarly situated participants and their covered dependents. The Plan Administrator may delegate certain discretionary authority to one or more individuals, entities, or committees.

Your participation in the Plan does not guarantee your continued employment with the company. If you quit, are discharged or laid off, this Plan does not give you a right to any benefit or interest in the Plan except as specifically provided in the Plan document.

Future of the Plan

The company intends to continue the Plan at this time. However, the company reserves the right to amend, change or end the Plan, in whole or in part, at any time for any reason.

Plan Type

- The Plan is a group health benefit plan providing:
- hospital expense coverage
- surgical expense coverage
- major medical expense coverage

Source of Funding

The Plan is funded by company and participant contributions. Benefits are paid solely from Plan funds.

Plan year

The Plan year begins on January 1, 2006 and ends the following December 31, 2006.

Claims Administrator

The Plan Administrator has delegated certain administrative functions to the Claims Administrator. The Claims Administrator is Lumenos.

Claims Fiduciary

The Claims Fiduciary identified below has been delegated with the final and binding discretionary authority to decide all questions of fact and to interpret the terms of the plan for the purposes of making benefit claim determinations. The Claims Fiduciary is Lumenos.

Notice Regarding Cost Sharing And Certain Discounts

Some of the contracts with medical, dental, and vision providers may allow discounts, allowance, incentives, adjustments and settlements. These amounts are for the sole benefit of the Plan and the Plan will retain any such payments. Claims submitted to the Plan may have copayment and the Deductible amounts calculated according to the provider's charge for covered expenses without regard to the applicable discounts, allowances, or incentives.

Terms to Know

Definitions included here will help you understand your Lumenos plan benefits.

Bridge

If you use your annual company allocation to your HRA and you need additional services from the Traditional Health Coverage, you will have to pay a specified out-of-pocket amount before the Traditional Health Coverage begins. This is called your Bridge.

Your Bridge is:

- $500 -single coverage
- $1,000 - family coverage

If you have been in the Lumenos plan for more than a Plan year, you may have money saved up in your HRA from previous Plan years. If so, you may have enough to cover your Bridge – and not pay anything out of your pocket before the Traditional Health Coverage begins.

Change in Status

An event that permits changing insurance coverage.

Claims Administrator

Organization contracted by Company who provides administrative services for specific Company benefit plans offered to Company employees and their dependents.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

A federal law that enables you or your enrolled dependents to continue medical and dental coverage in the event that you or they lose coverage as the result of certain qualifying events.

Covered Providers

Medical benefits extend to covered services provided by licensed providers as follows:

- Medical doctors
- Osteopaths
- Podiatrists
- Physical and occupational therapists
- Midwives
- Speech therapists
- Licensed clinical psychologists

Provided they practice:

- Within the scope of their license
- Within the scope of generally accepted medical practices
- Who are recognized by the state in which they practice

- Licensed clinical social workers and licensed marriage, family and/or child counselors are also covered. They must either:

  Be licensed or certified by the appropriate governmental authority having jurisdiction over such licensure or certification in the jurisdiction where the provider renders service to a retiree or spouse, or

  Be a member or fellow of the American Psychological Association if there is no licensure or certification in the jurisdiction where that provider renders service to a retiree and their spouse.

Providers who are professionally registered in their state, but do not meet these criteria will not be covered.

Custodial Care

Care which consists of services and supplies used to assist an individual in the activities of daily living, whether or not the person is disabled. These services and supplies are considered custodial care, regardless of who prescribes, recommends or performs them. However, when room and board and skilled nursing services must be combined with other therapeutic methods to establish a program of medical treatment, they are not considered custodial if:

- they are provided in an institution covered by the Lumenos plan
- this care can be reasonably expected to substantially improve the patient's medical condition

Deductible

Your annual deductible is the combination of your annual allocation and your Bridge. You meet your deductible by spending your HRA on covered services and paying your Bridge either out of your pocket or with HRA savings. Once this occurs, Traditional Health Coverage begins.

Domiciliary Care

Care that is provided or taking place in the home.

Durable Medical Equipment (DME)

Coverage is provided for rental or, at the discretion of the Plan, purchase of durable medical equipment, which is prescribed by a professional provider and required for therapeutic use.

If purchased, charges for repair or Medically Necessary replacement of durable medical equipment will be considered a covered expense.

Covered items include, but are not limited to: crutches, commodes, hospital beds, nebulizers, monitoring equipment, wheelchairs

Emergency Services

The Lumenos plan covers medical, surgical, hospital, and related health care services and testing including ambulance service, required for serious accidents, sudden illness, or any condition that, if not treated immediately, may result in serious long-term medical complications, loss of life, or permanent impairment to bodily functions.

Family Medical Leave Act (FMLA)

Provides unpaid leaves of absence with job protection for as long as 12 workweeks, for birth of a child, newborn care, adoption or foster care placement, or the serious health condition of an employee, or an employee's spouse, child, or parent.

Free-Standing Surgical Facility

An institution that meets all of the following requirements:

- Medical staff of physicians, nurses, and licensed anesthesiologists
- Maintains at least two operating rooms and one recovery room
- Has immediate access to diagnostic laboratory and X-ray facilities
- Has equipment for emergency care
- Has a blood supply
- Maintains medical records
- Has agreements with hospitals for immediate acceptance of patients who need hospital confinement on an inpatient basis
- Is licensed in accordance with the laws of the appropriate legally authorized agency

Full-Time Student

An eligible dependent child who regularly attends an accredited school on a full-time basis as defined by the school (usually 12 hours for undergraduate or nine hours for graduate work on a semester system) and who normally resides with you in a parent-child relationship except while away at school.

Home Health Care Agency and/or Services

A hospital or a nonprofit or public agency which:

- Primarily provides skilled nursing services and other therapeutic services under the supervision of a physician or a registered graduate nurse
- Is run according to rules established by a group of medical professionals
- Maintains clinical records on all patients
- Does not primarily provide custodial care or care and treatment of the mentally ill
- Is licensed and runs according to the laws

Hospice

Hospice is a health care program providing a coordinated set of services rendered at home, in outpatient settings, or in institutional settings for covered persons suffering from a condition that has a terminal prognosis.

To be covered, the hospice program must be licensed and the attending physician must certify that the terminally ill covered person has a life expectancy of six months or less. Charges incurred during periods of remission are not eligible under the provision of the Lumenos plan.

Hospital

A legally-constituted hospital that offers 24-hour resident service for patients. Hospitals have professional staff, nursing services and physical equipment that satisfy the legal requirements of the state, province, county, city or community in which they are established.

Inpatient Rehabilitation Facility

Coverage is provided for inpatient rehabilitation facilities. Most people who are admitted to an inpatient rehabilitation facility are recovering from injuries or illnesses that severely impair their physical functioning or understanding. These include strokes, spinal cord injuries, traumatic brain injuries, chronic pulmonary problems, neurological disorders and other debilitating conditions.

Administered by treatment teams, individual patient programs can include these services:

- Behavioral medicine
- Case management
- Dialysis
- Nutrition services
- Neuropsychology
- Occupational therapy (OT)
- On-site orthotic and prosthetic services
- Physical therapy (PT)
- Psychology
- Recreation therapy
- Rehabilitation engineering and technology
- Rehabilitation nursing
- Social work
- Speech and language therapy
- Vocational and community re-entry services

Medically Necessary

Medically necessary care is defined as:

- commonly recognized by the appropriate medical specialist, within standards of good practice
- appropriate, effective and consistent with the diagnosis or treatment of an illness or injury
- the appropriate supply or level of service that can be safely administered
- provided by a practitioner, hospital or covered provider
- a drug or supply approved by the U.S. Food & Drug Administration (FDA)

Medically necessary care is not:

- experimental or investigational in nature
- primarily for the convenience of the patient or covered provider
- provided primarily for the purpose of medical or other research

- care that does not require the technical skills of a medical, mental health or dental professional
- care that is more costly than care that could safely and adequately be furnished in an alternative setting
- scholastic, educational or developmental in nature, or intended for vocational training

Non-occupational

For non-occupational illness or accidents, any sickness or accident not related to work, you (or your covered dependents) are not entitled to Workers' Compensation benefits.

Qualified Medical Child Support Order (QMCSO)

A QMSCO is a court order, which requires the Company to provide health care coverage to the dependent child named in the order. It is not the equivalent of a divorce settlement requiring a named parent to provide health care insurance

Reasonable and Customary (R&C) Charge

A Reasonable and Customary (R&C) charge is the charge for a particular service or procedure that is customarily charged by doctors in the community in which the service or procedure is performed. In determining the Reasonable and Customary charge, the Plan Administrator:

- reviews charges published by Ingenix (as updated semi-annually)
- takes into account the physician's or surgeon's degree of specialized knowledge and skill
- considers the nature and severity of the patient's condition, and that unusual circumstances or medical complications may require additional time, skill and experience in connection with a particular service or procedure

NOTE: The charge for the same service or procedure may vary from one community to another, and even within a community.

IMPORTANT! Reasonable and customary charges are determined by the Plan Administrator in accordance with generally accepted principles and applied by the Plan Administrator on a uniform and consistent basis where there is not a Reasonable and Customary rate published by Ingenix for such charges.

Semi-Private Room Rate

Means the room and board rate of any institution for Semi-Private rooms. "Semi-private rooms" are accommodations with two or more beds that are classified by the institution as Semi-Private. If the institution does not have Semi-Private rooms, then that institution's "Semi-Private room rate" will be deemed to be the most common daily room and board rate for Semi-Private rooms in similar institutions in the area. The term "area" means a city, county or any greater area necessary to obtain a representative cross-section of similar institutions.

Transplant Services

The medical, surgical, and hospital services, and immuno suppressive medications required to perform any of the following human-to-human organ or tissue transplants: kidney, cornea, bone marrow, lung, liver, or pancreas.

Urgent Care

Conditions that need immediate attention from a doctor or nurse, but are not critical or life threatening.

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